Children's Integrated Services
Family Support Services Pilot

Evaluation Report: Cycle 1

June 1, 2007 through August 31, 2008

Pilot Regions: Agency of Human Services Districts
Franklin Grand Isle; Springfield; Hartford

Prepared by Christina Strobridge, RN, MAT, Coordinator, Performance–based Family Support Services Pilot
for:

Children's Integrated Services; Child Development Division; Department for Children and Families;
Agency of Human Services
103 South Main Street, 2 North
Waterbury, VT 05671
1-800-649-2462 or 802-241-3110
http://www.dcf.state.vt.us/cdd/

Evaluation Report for Children's Integrated Services Family Support Services Pilot: June 1, 2007-August 30, 2008

I. **BACKGROUND:** The Children's Integrated Services Family Support pilot grant is managed by the Child Development Division (CDD) of the Department for Children and Families (DCF) within the Vermont Agency of Human Services (AHS). The CIS Family Support Pilot is one of four Agency of Human Services (AHS) Performance- based grants established to test the use of Medicaid Global Commitment dollars.

a. Purpose of CDD's Children's Integrated Services

CDD's Children's Integrated Services (CIS) works to combine three prevention, early intervention and treatment programs into one child development and family support services system. These services and the CDD CIS system result in positive outcomes for pregnant and postpartum women, children birth through age 6, and their families. This purpose reflects many of the themes from the Agency of Human Services reorganization to improve child and family outcomes such as providing holistic services, effective service coordination, flexible funding to address gaps in services, prevention, collaboration, communication, continuous improvement, and accountability.

b. Purpose of CDD's CIS Family Support Pilots

CDD's performance-based Family Support Pilot focuses on discovering the commonalities and systems issues connected to integrating family support services across three services systems brought together under CDD by AHS reorganization: Maternal Child Health (MCH) nursing services formerly known as the Healthy Babies, Kids and Families (HBKF)program, Early Childhood and Family Mental Health (ECFMH) services formerly known as the Children's Upstream Services (CUPS) program, and Early Intervention (Part C) services formerly known as Family Infant and Toddler (FITP) Program. Each of these once separate systems of care has a family support component. A secondary hypothesis of the CIS Family Support Pilots is that the shared aspect of family support services provides a controlled arena for learning about integrating the full complement of all three programs' services as CIS is envisioned, including effective funding and billing mechanisms.

The first grant period was 15 months. It began on June 1, 2007 and ended August 31, 2008. A second 10-month grant cycle started September 1, 2008 and ends June 30, 2009. The four CIS Family Support Pilot grantees are located in three AHS service regions: Franklin/Grand Isle; Springfield; and two sites in Hartford.

Region	**Franklin/Grand Isle**	**Hartford**	**Hartford**	**Springfield**
Grantee	The Family Center of Northwestern Vermont	The Orange County Parent Child Center	The Family Place	The Springfield Area Parent Child Center
Partners	VT Dept of Health (MCH) Northwest Counseling and Support Services (ECFMH) Franklin County Home Health Agency (VNA)	VT Dept of Health (MCH) Clara Martin Center (ECFMH) VT/NH Visiting Nurse Association (VNA)	VT Dept of Health (MCH) Health care and Rehabilitation services of Southwestern VT (ECFMH) VT/NH Visiting Nurse Association (VNA)	VT Dept of Health (MCH) Health care and Rehabilitation services of Southwestern VT (ECFMH) VT/NH Visiting Nurse Association (VNA)

c. Overall Goals of the Family Support Pilot:

1) To increase child and family access to high quality child development services

2) To make a positive difference in the health, social and economic well being of the recipients of these services

3) To test a different funding mechanism (performance -based grants) for the provision of health-based family support services to Medicaid enrolled families with young children

4) To strengthen the implementation of the Children's Integrated Services Initiative with a particular emphasis on outreach, engagement, referral, and the delivery of family support services; and

5) To support a more comprehensive approach to service delivery including supporting time for delivery direct services, group education, team and supervision time, documentation and other record-keeping requirements.

d. Summary of Required Grantee Activities:

1. The grantee provides Healthy Babies Kids & Families (HBKF) Family Support Services to pregnant women, children and families within the context of DCF/CDD Children's Integrated Services (CIS) and work collaboratively with the DCF/CDD Children's Integrated Services (CIS) state team and the local CIS Regional Resource Team in providing services to eligible participants. The goal of this task is to begin integration of family support services across three targeted service areas within CIS. Specifically, the grantee provides Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) services through outreach, initial identification and referral for all eligible pregnant women and children, also within the context of the regional CIS team.

2. The grantee hires qualified staff as defined by the state CIS team to carry out services in the home and in other relevant locations desired by the family. One full time equivalent (FTE) provides services to an ongoing (point in time) caseload of about twenty eligible families, and may be either a bachelor's or master's prepared staff person. The caseload may include pregnant women and children birth to school age and a mix of families with varying needs and levels of intensity.

3. The grantee assures that the delivery of family support services is guided by the pilot outcomes, goals and objectives; includes the use of a Touchpoints prevention and anticipatory guidance framework; and uses other best practices as identified by the region and the state office related to long term, meaningful changes that support child and family health and well being. The grantee uses family support practices that incorporate a family-centered approach that engages families in meaningful outcomes planning and strategies, and empowers families to nurture and support the development of their child.

4. The grantee provides services that comply with all relevant federal and state laws and regulations and assures compliance with any CIS procedures outlined for fiscal reimbursement, grant reporting, data collection, hiring of qualified staff, supervision and outcomes-based planning for and with eligible families. Medicaid EDS claims data is monitored on a monthly basis to ensure that fee-for-service billing does not occur in addition to receipt of grant funds.

5. The grantee utilizes reliable child development screening tools, including the Ages and Stages Questionnaire (ASQ) and the Early Language Mastery Scales (ELMS), or another developmental

screening tool recommended by the state or the American Academy of Pediatrics, Vermont Chapter. Services occurring in a group follow an organized curriculum which addresses the subject areas and or practices covered in Touchpoints, Path To Parenthood, Growing Up Healthy, the CUPS Handbook, Supporting and Strengthening Families (Dunst, Trivette and Deal), and resources from headstartinfo.org as well as other respected resources that support this work such as the AAP Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, 3rd Edition..

6. The grantee documents all contacts with the family in the child/family's file/record, which is available for review by the CIS state team as requested for monitoring or other specific purposes. A brief summary of the work completed during each contact, including screening, assessments, education and counseling, etc., is documented in the record. Documentation also includes progress on changes in health, social-emotional, and economic well being; what increases in or sustaining of positive parenting behaviors and family capacities have occurred; and identifies any barriers to progress toward individual child and family outcomes.

7. The grantee assures the development of a child and family outcomes plan. The plan is developed within the CIS resource team process, including a review of all new referrals; gathering and review of all pertinent screening information from the family and other sources; and an on-going multi-disciplinary assessment. The plan includes outcomes that are meaningful to families and the strategies families think will work for them to produce those outcomes. Examples of plan outcomes include positive changes, support for existing positive behaviors and activities in parent-child relationships (for example, enjoyment of parenting), and improved health, social and economic well being for parents and their families. The child and family outcomes plan is reviewed at least every six months with the family and the CIS team to assess what strategies are working and what may need to change.

8. The grantee identifies all transition services as part of the plan if a family/child will be leaving services, changing provider(s), and/or beginning a new service or provider relationship. The grantee will assure that families are connected to other systems of care in the community.

9. The grantee participates in periodic, ongoing professional development, in-service training and technical assistance related to the goals, strategies and outcomes expected from this grant. Each staff person employed through this grant funding will have an Individualized Professional Development Plan. The grantee participates in a pilot orientation and scheduled technical assistance activities as a pilot region.

Children who suffer abuse or neglect, or have parents who suffer from mental health problems (especially maternal depression), substance abuse, or family violence have as high a probability of experiencing developmental delays as do children with medical conditions that are automatically eligible for Part C services under the Individuals with Disabilities Education Act (IDEA).

From Science to Public Policy: Early Intervention for Abused and Neglected Infants & Toddlers, Zero to Three Foundation. 2006.

II. DESCRIPTION OF EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) TOPIC AREAS AND TYPES OF FAMILY SUPPORT WORKER ACTIVITIES

a. **EPSDT and Managed Care:** Most children in Medicaid are in managed care and remain entitled to the full EPSDT benefit. EPSDT is a required benefit for all "categorically needy" children (e.g., those who have poverty-level income, receive Supplemental Security Income, or receive federal foster care or adoption assistance). EPSDT's rules reflect the greater health needs of low-income children, as well as children whose special health needs qualify them for assistance. Low-income children covered by public insurance are more likely to be born at low birthweight, which increases the risk for lifelong disability, and more likely to be in fair or poor health, to have developmental delays or learning disorders, or to have medical conditions (e.g., asthma) requiring ongoing use of prescription drugs. For these children, Medicaid is essential to ensure access to preventive and developmental services. [1]

b. **Medicaid EPSDT Core Activities** include outreach, informing, screening, assessment, and assistance. The purpose of Medicaid case management is to assist individuals in gaining access to needed medical, social, educational and other services. Case management activities, as described under the Vermont Medicaid State Plan include: coordination, advocacy, monitoring and evaluation as related to the individualized plan of care.

Topic Areas Related to EPSDT Core Activities: outreach, informing, screening, assessment, and assistance

- ¬ Health Maintenance
- ¬ Prenatal health issues competency
- ¬ Health history/individual concerns and/or goals
- ¬ Access to prenatal care
- ¬ Source of ongoing obstetric/prenatal care
- ¬ Making/keeping recommended prenatal visit appointments
- ¬ Immunizations
- ¬ Screenings
- ¬ Signs of premature labor
- ¬ Illness management, infectious disease
- ¬ Sexual safety re: HIV/STI prevention
- ¬ Work environment and responsibilities
- ¬ Physical activity
- ¬ Oral Health; Access to and utilization of a dental home
- ¬ Habits
- ¬ Nutrition
- ¬ Hunger/satiety
- ¬ Diet changes
- ¬ Weight gain
- ¬ Vitamins/supplements
- ¬ Food resources, safe cooking equipment and adequate refrigeration
- ¬ Mercury containing foods
- ¬ Plans for infant feeding – breast or formula
- ¬ Support
- ¬ Relationship with partner, family, other informal or formal supports
- ¬ Understanding of Medicaid benefits and system
- ¬ New to community
- ¬ Specialized learning needs
- ¬ Childbirth education preparation; assist with access to classes
- ¬ Client needing information or assistance to access other community programs
- ¬ Safety
- ¬ Emergency contacts
- ¬ Stable housing, rental/tenant rights and responsibilities
- ¬ Seat belt use
- ¬ Home environment: lead, water and air quality, fire safety, carbon monoxide, pesticides, chemicals, paints, cleaners, etc.
- ¬ Tobacco use or exposure to second hand smoke
- ¬ Alcohol or other drug use
- ¬ Sexual safety
- ¬ Trauma and abuse
- ¬ Planning for Postpartum
- ¬ Postpartum depression
- ¬ Sibling preparation
- ¬ Work plans
- ¬ Parenting resources - Infant care and supplies
- ¬ Plans for contraception
- ¬ Plans for quality child care
- ¬ How to choose a pediatric provider
- ¬ Establishing a medical home for ongoing well child care

[1] EPSDT: An Overview, The Commonwealth Fund, September 2005

c. **Required Knowledge Areas For Family Support Workers To Support EPSDT Activities** include: Medicaid benefits; Access to a medical and dental home; Routine health care maintenance and pregnancy care; Child growth & development; Family systems and dynamics; Family-centered care; Cultural competence; How to assist families in accessing and utilizing the health care system effectively, as well as other community resources and supports; Identification and assistance with barriers to preventive health care (personal & systems issues); Assist with life skill development re: access to health care and solving problems; Empowering and advocating for individuals; Strengthening families in their roles as parents; Seeking information and referral, organizing transportation; Providing health education; Communicating and coordinating with other providers as a team in the family plan; Adult learning styles.

d. The skills and knowledge necessary for promoting the social and emotional development of children and for recognizing and addressing mental health issues are not the purview of any one discipline. *The Family Support Worker Competencies for the HBKF System of Care* and the *Vermont Early Childhood and Family Mental Health Competencies* are examples of professional competencies intended to guide the preparation and ongoing professional development of family support service providers in various fields who have a role in supporting families with young children.

e. **Criteria for Receipt of CIS Family Support Services:** The clients addressed in this population are defined as families who are enrolled in Medicaid, are pregnant or who have children ages birth to six. In addition, families are struggling with one or more of the following:

1. The parent(s) are very young adolescents (17 or younger).
2. The parent(s) have significant cognitive delays that make the routines of parenting difficult to integrate and/or carry out in a consistent fashion.
3. The parent(s) have mental illness and/or depression that interfere with the routines of parenting and/or recognition of the child's needs.
4. The parent(s) are abusing drugs or alcohol.
5. The family is homeless or the parent(s) are unable to meet basic family needs for shelter, food, or clothing.
6. The parent(s) have a history of chronic childhood abuse and neglect or other childhood trauma such that they have not learned parenting and relationship skills.
7. The parent(s) have a history of domestic violence and/or poor anger management.
8. The parent(s) have unrealistic expectations of the infant and/or demonstrate a lack of secure attachment to the infant.
9. The family is isolated, unable, and/or unwilling to utilize other community systems of support.
10. The parent or child has significant medical problems that contribute to the stress and disorganization of the family systems.

III. EVALUATION COMPONENTS:

a. **Purpose of Evaluation Report:** The purpose of this evaluation report is to evaluate the attainment of overall goals of the CIS performance-based Family Support pilot at the end of the first evaluation cycle. The following components were used to guide the evaluation of the goals: CIS Family Support Pilot Desired Results, Goals, and Performance Measures and Data Sources

b. **Desired Results, Goals, Performance Measures and Data Sources:** (Please refer to Figure 1). Measurements of performance usually includes quantitative and/or qualitative data used to describe and assess an initiative as it pursues its goals. The Desired Results for the CIS Family Support Pilots are intricately linked to a bigger context of early care, health and education for children in Vermont. For this reason, they are aligned with the Agency of Human Services and Building Bright Futures Outcomes. The following chart lays out the relationships and associated data sources.

Figure 1: Desired Results, Performance Measures, and Data Sources for CIS Family Support Services Pilot

Building Bright Futures/AHS Outcomes with Core Indicators	CIS Family Support Services Pilot Targeted Goals	CIS Family Support Services Pilot Desired Results, Performance Measures and Data Sources
Pregnant women and young children thrive Core Indicator 1: % of women smoking during pregnancy Core Indicator 2: % of WIC-enrolled children (ages 2-4) who are overweight	1. Improve pregnancy outcomes by helping women improve their prenatal health	**CIS Pilot Desired Result:** Client population begins prenatal care with a health care provider within the first trimester and continues to receive adequate ongoing prenatal care throughout the pregnancy. **Performance Measure**: Timing of first prenatal visit and frequency of ongoing prenatal visits **Data Sources:** File review Family Outcomes Survey
Children are ready for School Core Indicator 1: % of children ready in all five domains of child readiness for Kindergarten Questionnaire Core Indicator 2: % of children in out-of-home care who are in a quality environment (data not currently available from state) Supporting Indicator: % of regulated Early Childhood Programs which are Nationally accredited or have 4-5 STARs	2. Increase access to high quality prenatal and child health and development services	**CIS Pilot Desired Result:** Children's growth and development are on target **Performance Measure**: Children show positive social-emotional skills (including social relationships) with peers and adults **Data Sources:** File review: Observation notes, Initial and ongoing assessment Developmental screening results Interview with family at six month review

Children live in stable and supported families Core Indicator 1: Rate of substantiated victims of child abuse and neglect Core Indicator 2: Number of new families at risk (single, teen parent under 20 years old with less than 12 years of education)	3. Improve children's health and development by helping parents provide sensitive and competent caregiving	**CIS Pilot Desired Results:** Parents, families and caregivers help their children develop and learn **Performance Measure**: Family reports positive gain **Data Sources:** Family Outcomes Survey File review: progress notes, Interview with family at six month review
Children live in stable and supported families Core Indicator 1: Rate of substantiated victims of child abuse and neglect Core Indicator 2: Number of new families at risk (single, teen parent under 20 years old with less than 12 years of education)	4. Improve family development by helping parents develop a vision for future family planning, completing education, finding work	**CIS Pilot Desired Results (A):** Families have the supports they want and need to meet their basic needs: education, job, food security, stable housing, transportation, health and dental care, personal and household, child care, safe neighborhood **Performance Measure**: Number and percent of children with an ongoing health care provider (medical and dental) **Data Sources:** File review **CIS Pilot Desired Results (B):** Families know their rights and advocate effectively for their child **Performance Measure**: Family reports they know their rights and can advocate effectively **Data Sources:** Family Outcomes Survey
Outcome to be decided by Building Bright Futures Core Indicator: To be decided by Building Bright Futures Council	5. To strengthen the implementation of CIS with particular emphasis on outreach, engagement, referral and delivery of Family Support services	**CIS Pilot Desired Results** The framework for Children's Integrated Services is implemented as designed (Refer to CIS Technical Assistance Guide, Appendix D: Desired Results, Proposed Performance Measures, and Data Sources) **Performance Measure**: Percent of target population using CIS **Data Sources:** CIS Encounter data

c. **Evaluation Design:** The *Exploratory* evaluation[2] is designed to see what insights can be gained about the areas where the complexity of the initiative is not yet understood or articulated. It asks and seeks to answer the following questions: What happened? What difference did it make? What has been learned? How will it inform the future?

d. **Continuous Quality Improvement:** (Please refer to Figure 2). CIS is committed to Continuous Quality Improvement (CQI) as described in the CIS TAG document:

> "A CQI system is dynamic. It has desired results, performance measures, data sources, and strategies. In a regular and ongoing manner it assesses, through a variety of monitoring and review methods, the desired results and strategies (activities) that guide service provision. The CQI system is used in a systematic review and evaluation of data (formal and informal) and is used to develop program improvement strategies, revise or affirm the desired results and strategies, and focus resources."[3]

Figure 2: Continuous Quality Improvement

[2] Designing Initiative Evaluation: A Systems-Oriented Framework for Evaluating Social Change Efforts. W.K. Kellogg Foundation 2007.

[3] Technical Assistance Guidance (TAG document) for Regional CIS Teams, version 1.5. Children's Integrated Services, Vermont Child Development Division. September 2007.

e. **Summary of Data Sources:**
There are four primary sources of data for use in evaluating the work of the CIS performance-based Family Support Pilots.

- **Narrative Summaries:** Each grantee wrote a periodic Narrative Summary with input from their CIS Regional teams. Each of the four grantees submitted a first quarter Narrative detailing their experience from June 1, 2007 through October 31, 2007. The second report covered the time period from November 1, 2007 through March 31, 2008, and the final reports examined the period from April 1 through August 31, 2008. Information from the reports highlighted themes across regions and directed the state CIS team to issues of priority.

- **File Review:** Representatives from the CDD CIS team, including the grant coordinator, reviewed a selective sampling of files from each pilot site for several purposes. This was the first time that Family Support files were reviewed with the goal of obtaining a baseline understanding of how pilot sites are documenting service delivery and to inform future guidelines for CIS documentation policies and procedures. The other goal was to obtain data related to the selected CIS desired results.

- **Family Surveys:** An adapted version of the Family Infant and Toddler Part C Family survey was sent to all pilot families who had been receiving services for at least 2 months. The survey was mailed in May 2008 for the first grant cycle. It was used to collect desired results data and as a quality assurance measure.

- **Encounter Data:** Each grantee submitted data monthly regarding their client encounters: name, address, Medicaid number, codes for service type, service provider, and beginning in January 2008 at the direction of AHS and OVHA, units of service for the individuals served by the CIS Family Support Pilot that month. It's purpose was for access and utilization data related to the desired results, as well as for monitoring and reporting to state and federal entities.

IV. SPECIFIC DATA FINDINGS AND INTERPRETATION RELATED TO REQUIRED GRANTEE ACTIVITIES AND DESIRED RESULTS:

NARRATIVE REPORTS SUMMARY:

a. **Purpose:** Information from the Narrative reports highlighted themes across pilot regions as well as insights for CIS as a whole and directed both the regional and state CIS teams to issues of priority.

b. **Process:** Each grantee periodically wrote a Narrative Summary with input from their CIS Regional teams. Each of the four grantees submitted a first quarter Narrative detailing their experience from June 1, 2007 through October 31, 2007. The second report covered the time period from November 1, 2007 through March 31, 2008, and the final reports examined the period from April 1 through August 31, 2008.

c. **Discussion of Findings:**

Changes to Direct Service Work: All four sites reported increased ability to serve families with more intensive needs and difficult-to-engage families due to flexible funding to cover additional expenses for providing service such as meeting time and follow-up activities. This, in turn, supported increased collaboration with partners. In three of the four sites, the Parent Child Center Director was actively and directly involved in overseeing and interpreting the pilot work which helped significantly with the

systems and big picture issues of implementation within the context of CIS. Several sites reported using the beginning of the grant period to determine new processes for doing business within the CIS model of primary service provider and consultation team. Two pilot sites were able to hire adequate staffing for family support services, filling existing vacancies. Several sites focused on cross-training staff previously dedicated to just one program. All sites designated a staff person to oversee the details of the pilot and all sites involved a billing/data management person from their staff.

Implementation of CIS Elements and Infrastructure: While the specifications for the CIS Family Support Pilots did not require or expect full CIS implementation, the work necessitated implementing some aspects of the CIS elements as described in the TAG document to enable infrastructure for integrating family support services from three programs into one. This work also aligned with the pilot goal for the strengthening the implementation of the CIS initiative. Each of the four pilot sites created a multi-disciplinary clinical consultation team to respond to referrals. Consistency in language and terms is a challenge in integrating different programs. Names for these clinical teams vary by region but for the purposes of this report these teams will be referred to as they are named in the TAG document: Multi-disciplinary Clinical Consultation Teams, or clinical teams for short. The clinical teams work as a sub-group of the three regional CIS teams (Hartford has 2 multi-disciplinary clinical consultation teams within their shared regional CIS team). Membership on all teams includes representatives from maternal child health services (Family support worker and nurse), early intervention services, and early childhood and family mental health services at a minimum. All the teams chose to expand team memberships. Two chose to include specialized child care, two included Reach Up/Economic Services, and two included Family Services.

One Team Structure

i. Two of the four sites were initially constrained by VNA MCH nursing staff shortages and lack of engagement with CIS. By the middle of the pilot period, the involvement had improved due to hiring. In those two areas, direct service nurses represent MCH at the clinical meetings. In the other two sites, the VNA MCH nursing director participates. VNA members accept referrals from the team but typically do not bring referrals. Efforts at the local and state level to effectively partner with VNA administration in the pilots and for the overall CIS initiative continued throughout the pilot cycle. In addition to local conversations, State CIS team liaisons have been working directly and actively with members of the Vermont Assembly of Home Health Agencies and to increase the collective understanding of what role the VNA realistically plays in CIS service delivery and to collaboratively address some of the issues. Challenges for the VNA partners include not being reimbursed for team meeting time, heavy caseloads beyond CIS, consent and confidentiality issues, and policies, procedures, and billing mechanisms separate from AHS.

ii. Clinical teams meet weekly or every other week. The primary function for the teams during this grant cycle centered on referral and intake. Referrals for all the pilot clinical teams came primarily through the Maternal Child Health Coordinator for individuals participating in the WIC program at the Vermont Department of Health. Several teams began to work on and pilot a common referral form based on the HBKF Communication tool and the draft example from CIS in the TAG document. Referrals from Part C comprise a small portion of referrals in all regions. ECFMH has participated in the clinical teams but have not shared their referrals to date due to

issues with differing requirements for consent and confidentiality for the mental health field. The State CIS team continues to work with mental health administrators and AHS Consumer Information and Privacy Standards representatives to clarify collaboration and consent pathways.

iii. Roles and responsibilities on both the regional and clinical teams required continual attention and evolution. The multidisciplinary aspect brought comprehensiveness to family support services and required clear, shared understanding of what each member and their respective agency could do. For example, in one region, it clarified for the team the mental health partner's responsibility to do home visits instead of asking families to travel to a clinic site. In all regions, the teams struggled with defining the new role of the VDH MCH coordinator in one way or another. In two sites, the MCH coordinator acted as clinical team facilitator. The other two teams struggled more to define a common understanding of the way the role could function. VDH and representatives of the State CIS team worked together to create a MCH coordinator job description within the context of CIS but practical application has been a challenge because AHS reorganization placed MCH program services in CDD and the associated staff stayed at VDH.

iv. Developing consent forms and processes were an important early step in collaboration. Overall, there was, and continues to be, confusion and conflicting information about what consent and confidentiality must cover for CIS collaborative activities. Several teams felt the need to explore empanelment though none used it. The CDD CIS team felt strongly that empanelment was for child protection situations and did not fit the intention of CIS clinical consultation teams. Initially, due to more stringent consent and confidentiality requirements in their field, several mental health partners were reluctant to participate on the pilot clinical teams. The State CIS team sought consultation and then produced and shared additional guidance from the AHS legal staff, already at work on promulgating AHS-wide confidentiality and consent rules. In two regions, the mental health partners crafted the draft CIS consent forms now in use by the teams which enabled them to feel confidant that all ECFMH requirements were included. Currently, all four pilot sites have developed a shared CIS consent for referral form to use with the families served by the pilot which enables them to be able to consult with the multidisciplinary clinical team about referrals and service provision. In practice, consent and confidentiality issues continue to present challenges. (Refer to Appendix I: Consent and Confidentiality).

v. Outreach, referral, and engagement discussions changed to include more partners. Difficult-to-engage families remain difficult to engage but the teams began to find, in some cases, families already had relationships with one partner on the team, so that partner could act as bridge resulting in a higher success rate of engagement. Discussions about refining the referral process from WIC began in several regions due to the high refusal rates related to these particular referrals. These discussions expanded to consider outreach needs and criteria for all family support referrals to the clinical team, regardless of which door a family originally came through. Formally or informally, all teams developed a common description of the CIS team to use with families and providers. The state CIS team had plans at the beginning of the pilot period for producing outreach materials to support regional efforts which were cancelled due to budget shortfalls. Funding was restored in July with the new state fiscal year but then almost immediately put on hold again preventing development of any formalized outreach planning or resources.

More comprehensive approach: As a result of grant funding, all the pilot sites reported being able to assess needs and provide services more comprehensively and, when needed for those with more intense service needs, to provide more frequent contacts. All pilot sites pointed to the multidisciplinary clinical team as strength and a means to becoming more comprehensive in family support service delivery. The team structure resulted in improved communication and increased understanding of each others roles and responsibilities, though overall partnerships with ECFMH, VNA and the VDH continue to require active problem-solving before full participation occurs. Staff at several sites was cross-trained and/or reassigned. For example, instead of providing family support for just families enrolled in the former CUPS program, they were able to provide family support and EPSDT services for those enrolled in any of three services.

System changes related to alternative financing: All four pilot sites reported that, due to performance-based grant funding instead of fee-for-service billing, they were able to serve a small but significant portion of their caseload of individuals more intensively and have greater flexibility in how those individuals were served, resulting in better outcomes for those families. Two sites observed the grant funding allowed them to be more preventive versus reactive in their service delivery to families with less intensive needs as well.

i. All four pilot sites report that need in their communities exceeds the capacity of the grant funding. The system changes for service delivery aligned with the general trend all four of the pilots reported seeing: more and more families with increasingly complex needs and service issues. Importantly, they also each reported receiving more referrals than they had the capacity to serve under the grant. This has important implications for future financing and service delivery. Some sites discussed the need for triaging referrals, tightening referral processes to decrease time spent on clients who decline services, and combining more resources with more partners to extend their reach. All are worried.

ii. Stable and predictable budget: All four pilot sites appreciated the stability, flexibility, and predictability of grant funding as compared to the retroactive fee-for-service model. All four repeated their emphasis that the amount budgeted was not enough to serve the needs and cover the service costs in their communities.

iii. All four pilot sites reported that the funding was not enough to support meeting and supervision time in addition to providing services. Several sites noted that the pilot required additional administrative time not originally budgeted. There is no mechanism for payment for the VNA partner beyond the visit. Finding a means to reimburse agencies for “Not Home Not Found” visits is another priority for effective partnership. The reality is more families with more intensive needs require more primary service provider and teaming time, and more supervision time. The current economic downturn and increase in societal stressors amplifies the situation.

iv. At the end of the pilot period, it was discovered that there was misunderstanding between pilot sites and state team members about whether the pilot specifications were for serving families or for serving individuals. Medicaid funding, whether through fee-for-service billing or grant funding is governed by federal regulation which requires that all services, documentation, billing, and data collection be by individual. The grant language is inconsistent, using both families and individuals in its language, reflecting the best practice family-centered approach to

providing family support services. This highlighted the importance for all, once again, of clear and consistent language as well as providing clarity about tracking individuals.

d. **Next Steps**

Clarification of roles and services is important to all teams: Because of the evolving nature of the pilots and CIS as a whole, all teams continue to address the need for greater understanding of what each member can bring to the Family Support pilot work and to the overall CIS work. The state CIS team identified the need for general job descriptions in line with the TAG document's One Team description. Currently these exist in draft form for the Family Support worker and MCH coordinator. This work needs to continue.

CIS team partnerships focused on building the multidisciplinary clinical consultation team for family support services: clarifying roles, particularly for VNA staffing and participation, ECFMH participation, consent issues and capacity for home visiting, and operationalizing the MCH coordinator role. The state CIS team has worked with administrators to increase understanding of and participation in the CIS pilot work. They have worked with AHS legal resources to create additional guidelines for consent. They have worked with VDH and AHS to clarify the MCH coordinator status. All this work needs to continue.

Consistent paperwork, forms, and documentation processes with the capacity for interactive, electronic sharing of information and data collection for the clinical consultation teams: Priority for development is for consent, referral, the" One Plan" and support for outreach planning and materials. The lack of a shared means for communicating and documenting are a very real obstacle to full implementation. The state CIS team a template for referral and guidelines for consent forms to follow. All four pilot sites have made valuable contributions to creating and testing consent, referral and tracking forms and processes. The first draft of the One Plan will be piloted during the fall of 2008 and feedback from the pilots will be important. The state CIS team has begun formal planning with AHS IT to implement a shared electronic CIS database and client record. The timeline points to operationalizing in Fiscal year 2010 however, restricted state budgets and competing AHS IT priorities have currently delayed action beyond the planning stage. The state CIS team had plans at the beginning of the pilot period for producing outreach materials to support regional efforts which were cancelled due to budget shortfalls. Funding was restored in July with the new state fiscal year but then almost immediately put on hold again preventing development of any formalized outreach planning or resources.

Increased capacity to meet increasing needs in Vermont communities: Strategies for responding to increased need include sounding the alarm—informing and educating the public, lawmakers, state agency and partner administrators, creating criteria for triaging referrals, increasing efficiency and continuing to eliminate duplication of services, and exploring ways to combine more resources with more partners to extend reach.

Professional development opportunities and supports for the Family support worker with priority given to: engaging with hard-to-engage individuals; documentation and outcomes; using the One Plan: Regions have directed their own professional development activities during the pilot period. For example, one pilot site sponsored Touchpoints training, another site, through their CIS team, organized a shared ECFMH training. The state CIS team has not sponsored professional development activities for CIS pilots.

FAMILY SUPPORT PILOT FILE REVIEW SUMMARY:

a. **Purpose:** Throughout April 2008, members of the State CIS team conducted a review of pilot files kept by the four sites. The purpose of the file review was : 1) to gain a preliminary understanding of what is currently documented for Family Support Services provided by different agencies; 2) to propose common elements for CIS documentation considering what is currently in use, best practice standards, and the CIS vision; 3) to gather baseline data related to the stated Desired Results for the pilot work overall; and 4) to monitor use of Medicaid funds by comparing visits documented to encounter data and; 5) to see, read, and listen to the challenges , successes, and realities of the direct service providers and their administration firsthand in relation to documentation and the changes CIS creates .

b. **Process:** A representative sampling of files was reviewed at each site by at least two reviewers using a standard checklist, one per file. A list of proposed common elements for documentation grew from the observations and comments noted on each of the file review checklists (See sidebar, page 16). Feedback to the individual pilot sites about their files and documentation systems was organized around the proposed common elements which emerged from the reviews for the purpose of consistency across a spectrum of differing documentation practices (Refer to Appendix II: File Review). There was no expectation during this review that pilot sites meet all the common elements. They are still being defined and the first file review serves as a baseline.

c. **Discussion of Findings:** The reviewers found a range of documentation practices among the four pilot sites. Many of the selected performance measures proved to be aligned with standard documentation practices. For example, medical home information was available in 88% of the files already, although not in any systematic fashion. Specific requirements for data collection for the coming grant cycle will be articulated through technical assistance for the next grant cycle. (Figure 3)

   i. The CIS State team must come to agreement about core documentation standards before there can be further guidance to the field. It has been challenging to get the state team to act on procedural issues such as this.

   ii. Any discussion about data collection for CIS is not complete without including the crucial need for an electronic, shared, interactive, web-based database. Currently, CDD CIS is working with the AHS IT Department for such a database solution for CIS. The timeline points to operationalizing in Fiscal year 2010 but is jeopardized by limited state budgets and competing state technology priorities during the current economic downturn.

   iii. Core documentation must meet competing criteria: it must be realistic to accomplish in a busy home visitor's schedule; it must integrate with and support the One Plan documentation[4]; it must reflect progress toward outcomes; it must meet Medicaid audit and billing criteria; it must be able to stand up in a court of law; it must serve individual agency policy and procedure. What is necessary, what makes practical sense, what can be eliminated or adapted—all these factors foretell rich local and state

[4] Refer to: Technical Assistance Guidance (TAG document) for Regional CIS Teams, version 1.5. Children's Integrated Services, Vermont Child Development Division. September 2007.

discussions over the next year.

d. **Notable Themes**: The majority of individuals receiving services received some type of ante partum care. Over half the files reviewed included documentation of positive social-emotional skills. The majority of families noted positive gains in their child's development and/or learning. A majority of children had an identified medical home and a majority of families felt that they knew their rights and could advocate effectively for their child. A prevalent theme noted by the reviewers was that consistency in file documentation and organization was higher when the grantee (PCC director) directly oversaw the pilot work, even if day to day management had been delegated to a supervisor. A second theme regarding quality of documentation was that the quality of the progress notes (objectivity, relation to goals, signed, dated, etc.) and other file materials was high among direct service providers with Masters level preparation, noticeably less so among entry level staff . A theme directly related to this emerged around the need for supportive professional development opportunities for entry level and new staff about the basics of documentation.

e. **Documentation of Medical Provider Signature for Children 1-5:** The federal Centers for Medicaid and Medicare Services (CMS) closely monitor State Medicaid Plan compliance. Efforts to control Medicaid spending increased scrutiny under the recent administration. The Vermont State Medicaid Plan was recently reviewed and amended to ensure compliance with changing CMS requirements. Children between the ages of 1 and 5 receiving Medicaid services because they have been identified by a medical provider or a community program as "at risk of inappropriate health care service utilization, medical complications, neglect or abuse" will continue to require a medical provider signature on the initial case management plan and then annually or whenever there are significant changes to the plan. The medical provider verifies the medical necessity of the plan. Before CIS, this signature was obtained using the HBKF Communication Tool which includes case plan goals for the provider to review. In many areas this form is still used because it allows easy communication with the medical provider. The CIS One Plan draft version forms do not include a means for easily communicating initial case plan goals with and obtaining signatures from medical providers. The One Plan forms will need to be revised as soon as possible to allow this use. In the meantime, the state CIS team and local CIS teams need to work together to determine an efficient process for obtaining the medical provider signature for the targeted group of medically high risk children ages 1-5 receiving Medicaid services.

f. **Next Steps:** As it continues to pilot integrated family support services, and begins to pilot the One Plan draft, the state CIS team needs to determine priorities and create associated policies, procedures, trainings, and technical assistance to institute consistent documentation guidelines. Guidance to the field regarding documentation cannot go forward without state team and partner consensus because it so directly relates to the One Plan and the state's plans for expanding the CIS initiative. The state team needs to ensure agreement among all three service partners at all levels regarding the core standards. In addition, another pressing reason for operationalization of core documentation standards is that for the last two months of the next grant cycle (May and June 2009), the CIS performance-based Family Support Pilot sites have the opportunity to be eligible for enhanced case rates if their data shows desired results have been attained. The performance-based outcomes data is directly supported by the documentation.

Proposed Common Elements for CIS Documentation

- Contact information
- Medicaid Eligibility/Status/Billing information
- Referral Information/initial contact information
- Purpose of visits
- Consents signed and dated
  - CIS consent form
  - Complaint/Appeal process
- Each entry signed with name and credentials
- Each entry dated with day/month/year
- Progress notes are linked to goals. Participants ongoing response to services noted
- Progress note language is objective, factual and specific (vs. general and/or subjective)
- Handwriting is legible
- The following elements are captured as part of the One Plan document:
  - Contact/Summary sheet showing overview of activities including follow-up and coordination activities
  - Goals for service are clearly defined and easy to locate in file
  - Six Month Review of Service Plan and goals is documented
  - Changes to goals for services are clearly noted, signed and dated in file
  - Screenings and assessments are in the file, dated, signed, results clear
  - Transition and/or Discharge planning is documented in progress notes. Discharge date and reason is

Figure 3: File Review Summary for CIS Family Support Pilot Performance Measures (related to figure 2, page 8-9)

CIS Pilot Desired Result: Client population begins prenatal care with a health care provider within the first trimester and continues to receive adequate ongoing prenatal care throughout the pregnancy. **Performance Measure to be Tracked:** Timing of first prenatal visit and frequency of ongoing prenatal visits **Need**: Consistent method by each site for routinely capturing specific outcome-specific ante partum care data for pregnant and postpartum individuals.	**Discussion:** Specific tracking information about prenatal care was not defined or required for the first pilot cycle. The data was most readily available on the referral forms in 39% the files. 82% of respondents to the survey received prenatal care. **Data sources:** 59 files reviewed: 23 received prenatal care during pregnancy (Not able to determine if started in 1st trimester) 28 Family Outcomes Surveys: 18 indicated they received prenatal care beginning in the first trimester 5 received prenatal care after the first trimester 4 did not receive prenatal care 1 did not respond
CIS Pilot Desired Result: Children's growth and development are on target **Performance Measure:** Children show positive social-emotional skills (including social relationships) with peers and adults **Need:** Consistent method by each site for routinely capturing objective outcome-specific data related to positive social emotional skill development	**Discussion:** Tracking information specific to documenting positive social-emotional skills was not defined or required for the first pilot cycle in order to obtain a baseline. 58% of the files reviewed contained evidence of positive social-emotional skills. The data was most readily found in the progress notes and sometimes in the screening and assessment results. **Data Sources:** 59 files reviewed: 34 instances of documented positive social-emotional skills 9 in screening/assessment documents in file 25 in file progress notes
CIS Pilot Desired Results: Parents, families and caregivers help their children develop and learn **Performance Measure:** Family reports positive gains **Need:** Consistent method by each site for routinely capturing objective outcome specific data related to positive gains	**Discussion:** Tracking information specific to documenting positive gains was not defined or required for the first pilot cycle. 86% of the families responding to the survey indicated positive gains. 14% reported not experiencing positive gains. Teams did not have a formal 6 month review process for the first grant cycle **Data Sources:** 28 Family Outcomes Surveys (Question 2): 24 Reponses were between 'Usually' and 'Almost Always' on the scale 4 Responses were between 'Seldom' and 'Sometimes' 0 Interviews with family at six month review

CIS Pilot Desired Results (A):
Families have the supports they want and need to meet their basic needs: education, job, food security, stable housing, transportation, health and dental care, personal and household, child care, safe neighborhood

Performance Measure:
Number and percent of children with an ongoing health care provider (medical and dental)

Need: Consistent method by each site for routinely capturing objective outcome-specific data related to medical and dental home

Discussion: Tracking information specific to documenting medical and dental home was not defined or required for the first pilot cycle. 88% of the files reviewed had evidence of a medical home. 8% had evidence of a dental home. 71% of the families responding to the survey see a dentist regularly. 29% do not.

Data Sources:
59 Files reviewed:
- **52 had evidence of a medical home**
- **5 had evidence of a dental home**
- **2 had evidence of no dental home**
- **52 files had no available info re: dental home**

28 Family Outcomes Surveys:
- **20 have a dentist they see regularly**
- **8 do not have a dentist that was seen regularly**

CIS Pilot Desired Results (B):
Families know their rights and advocate effectively for their child

Performance Measure:
Family reports they know their rights and can advocate effectively for their child

Need: Consistent method by each site for routinely capturing objective outcome-specific data related to families being informed of their rights

Discussion: Tracking information specific to families knowing their rights and advocating was not defined or required for the first pilot cycle. 82% of the families responding to the survey report that they know their rights and can advocate effectively. 14% do not feel that they know their rights nor can advocate effectively. 4% are neutral.

Data Sources:
28 Family Outcomes Surveys
- **23 responses were between 'Good Job' and 'Excellent Job**
- **4 responses were between 'Poor Job' and 'Fair Job'**
- **1 response was in the middle of the scale**

CIS Pilot Desired Results:
The framework for Children's Integrated Services is implemented as designed as described in the CIS Technical Assistance Guide, Appendix D: Desired Results, Proposed Performance Measures, and Data Sources

Performance Measure:
Percent of target population using CIS

Need: Consistent method by each site for routinely capturing objective outcome-specific data related to utilization

Discussion: Tracking information specific to implementing CIS was not defined or required for the first pilot cycle.

Data Sources:
CIS Family Support Pilot Encounter data (access)

FAMILY SURVEY SUMMARY:

a. **Purpose:** The Family Survey provides an effective means for capturing feedback directly from service recipients and to evaluate and gather information to improve services to families. It was used to collect desired results data and as a quality assurance measure.

b. **Process:** In May of 2008, all CIS performance-based Family Support Pilot families who received services for at least 2 months were mailed a shortened version of the Family Outcomes Survey developed by the Early Childhood Outcomes Center with support from the Office of Special Education Programs, U.S. Department of Education. During the same time period, CIS Part C services mailed the full version of the survey to families receiving Part C services over the past year. Surveys were coordinated to ensure that each family received only one survey. All surveys were anonymous and confidential and the service providers did not see the original completed surveys. All answers to the pilot survey were aggregated to create an overall report of families' experiences with CIS Family Support pilot services.

c. **Discussion of Findings:** 84 surveys were sent to families receiving Family Support services through the pilots with an overall return response rate of 43%. Eight families were eliminated from the initial total to avoid duplication because they also were served by Part C and were sent the long survey instead. Eleven surveys were undeliverable due to families no longer at the address where service was provided, highlighting the frequency of moves within the population served. In the end, 65 pilot families received surveys and 28 families returned surveys (8=Franklin/Grand Isle; 7=Orange County PCC; 7= The Family Place; 6=Springfield Area PCC) and 24 raffle tickets were returned. Please refer to Appendix III: Family Survey for a copy of the survey and summary of results.

d. **Next Steps:** The family survey data ensures direct feedback from those who have received CIS family Support services and is therefore an important element of the data collected. The survey will be conducted again in the spring of 2009 during the second cycle of the pilot. Because Part C is required by federal regulation to conduct the family survey annually, work will be coordinated with Part C again this year. It is recommended that the goal for spring of 2009 is for a uniform version of the family survey to go to all families receiving CIS services in order to yield broader and more meaningful data collection.

ENCOUNTER DATA SUMMARY:

a. **Purpose:** The Encounter Data is Federal Utilization Data required by MOU and contractual agreement for reporting to OVHA about Global Commitment Medicaid dollars used to fund the CIS Family Support Service Pilot Grants.

b. **Process:** CIS performance-based Family Support Pilots submitted encounter data monthly to the CDD pilot coordinator for the each of the 15 months of the first pilot cycle. Encounter Data elements collected included: Name of Parent Child Center; Name of Direct Service Provider; Full Name of Family Support Services Recipient; Date of Birth; Medicaid Number; Mailing Address; Town of Residence; Procedure Codes, Mode/Method of Delivery (group education, home visit, Families Learning Together program, or other), Location of Service (Home, PCC, other) Dates of Service; Units of Service (beginning with February 2008 reports). Originally units of

service were not required. A directive from AHS in January 2008 to start collecting units of service is reflected beginning with the February spreadsheets.

c. **Discussion of Findings:** Over the 15 month grant cycle, the CIS Family Support pilot served a total of 253 individuals resulting in a combined average active caseload of 21.5 individuals per month receiving a combined average of 1,164 visits per month funded by a combined grant award of $244,807.00. Of the active caseload served per month a combined average of 2 individuals per month received intensive visits (defined as greater than 6 visits per month). Please refer to Figure 4: Encounter Data Summaries by Pilot Site and Figure 5: Funding.

Under traditional Medicaid fee-for-service billing, claims data (which is also federal utilization data) is submitted, tracked, and manipulated electronically. Reports can be generated and analyzed in a systematic manner with efficiency and accessed by multiple stakeholders. It has been a challenge to collect and analyze pilot encounter data without any connections to organized data systems within AHS. A request was made to OVHA to submit dummy claims for pilot units of service through EDS so that the data could be tracked and compared to traditional Medicaid billing. This request was denied. The Encounter data for this pilot cycle was tracked with Excel spreadsheets submitted monthly by each of the four pilot sites (60 separate spreadsheets). Tabulation of data for the grantees and the state has been by hand; cumbersome, time-consuming, and prone to error. Differences among pilot sites in use of coding and reporting templates also impacted the ability to manipulate the data. Connection to an AHS integrated web-based data management system is essential for management and reporting of Medicaid funds. Reporting information for the next 10 month cycle of the pilot will be through a case rate and processed through EDS. From the EDS data, the DCF business office will generate reports and participate in analyzing data. This change will significantly expand not only the checks and balances for managing the data but also the involvement of more diverse expertise and broader understanding across state departments.

i. Pilot sites were free to structure their service delivery in ways which best served the needs of their communities and the realities of their staffing and resources. For example, one site with a Families Learning Together (FLT) program used the pilot to expand supports (home visits, group education and bridging the summer gap in the FLT program) to a core group of those individuals with involved family support needs, also serving referrals beyond that core group to maintain an average pilot caseload of around one FTE or about 50 families. Another site experiencing staff changes and a short-term vacancy focused on preventative visits which resulted in higher number of overall clients seen and less intensive service frequency.

ii. As mentioned earlier, there was misunderstanding about whether pilot sites were tracking families or individuals. While all sites consistently and correctly submitted encounter data by individual, it was discovered that some sites were serving 2-3 children within a family, but tracking for only one individual as was the practice under fee-for-service billing. All sites provide family support services to more families than the pilot grant could support, funding the services through other programs such as Parents as Teachers within their overall agency budgets. Another observation gleaned from the misunderstanding was that, during this cycle, the project missed an opportunity to collect and compare data about all family support services emanating from Parent Child Centers. As integration of services for children moves forward, and as demand for family support services continually grows beyond capacity, it will be important to understand all the avenues and funding for family support in detail.

Figure 4: Encounter Data Summaries by Pilot Site

Orange County Parent Child Center (Hartford)

Month	Number of individuals	Number of Visits	Average number of visits per month
June 2007	9	19	2.1
July	21	57	2.7
August	18	33	1.8
September	15	29	1.9
October	24	52	2.2
November	24	61	2.5
December	24	50	2.1
January 2008	21	52	2.5
February	23	94	4.1
March	23	88	3.8
April	27	129	4.8
May	22	80	3.6
June	24	144	6
July	32	191	6
August 2008	27	110	4.1
Total Averages	**22.5**	**79.25**	**3.35**
Total number of visits = 1189			
Total Number of Unduplicated Individuals Served by pilot site = 56			

The Family Place (Hartford)

Month	Number of individuals	Number of Visits	Average number of visits per month
June 2007	26	59	2.3
July	23	44	1.9
August	24	114	4.8
September	25	107	4.3
October	31	151	4.9
November	31	161	5.2
December	31	168	5.4
January 2008	28	172	6.1
February	19	100	5.2
March	21	107	5.1
April	20	104	5.2
May	18	87	4.8
June	19	75	3.9
July	14	36	2.5
August 2008	16	32	2
Total Averages	**23.0**	**101.0**	**4.24**
Total number of visits = 1517			
Total Number of Unduplicated Individuals Served by pilot site = 46			

Springfield Area Parent Child Center (Springfield)

Month	Number of individuals	Number of Visits	Average number of visits per month
June 2007	19	38	2
July	22	41	1.9
August	21	40	1.9
September	16	20	1.3
October	6	7	1.1
November	19	29	1.5
December	20	39	1.5
January 2008	21	50	2.4
February	25	51	2
March	30	67	2.8
April	23	63	2.7
May	18	42	2.3
June	25	68	2.7
July	21	63	3
August 2008	22	77	3.5
Total Averages	**20.5**	**46.33**	**2.20**
Total number of visits = 695			
Total Number of Unduplicated Individuals Served by pilot site = 92			

Family Center of Northwest Vermont and Champlain Islands Parent Child Center (Franklin Grand Isle)

Month	Number of individuals	Number of Visits	Average number of visits per month
June 2007	13	64	4.9
July	16	63	3.9
August	17	57	3.4
September	18	39	2.2
October	15	54	3.6
November	20	85	4.25
December	21	85	4
January 2008	22	60	2.7
February	23	51	2.2
March	22	48	2.1
April	20	49	2.4
May	22	67	3
June	26	71	2.7
July	19	73	3.8
August 2008	22	59	2.7
Total Averages	**20.0**	**62.0**	**3.20**
Total number of visits = 925			
Total Number of Unduplicated Individuals Served by pilot site = 59 (FCNWVT=42, CIPCC=17)			

SUMMARY:

The AHS performance-based grant pilots, of which the CIS Family Support pilot is one, have provided the opportunity over the past 15 months to test a different funding mechanism for the provision of health-based family support services to Medicaid-enrolled families with young children. As a funding mechanism, performance based grants provided the grantee a known budget and funds in hand prior to service delivery. It also provided the opportunity for the grantee to take a more comprehensive approach to service delivery including supporting time for delivery of direct services, group education, team and supervision time, documentation and other record keeping requirements.

The pilot thus far shows that a performance based grant approach to funding services results in more flexible and responsive services. Families in the CIS Family Support pilot who needed it received a greater intensity of services than is possible than is possible under the HBKF Medicaid fee-for-service billing. Flexible funding provides support, for example, for the family support worker to address and follow Medicaid enrollment or disenrollment issues. The multidisciplinary team approach broadened the capacity to effectively evaluate and address client needs without duplication of effort. All of these aspects served to increase child and family access to high quality child development services.

Over the 15 month grant cycle, the CIS Family Support pilot served a total of 253 individuals resulting in a combined average active caseload of 21.5 individuals per month receiving a combined average of 1,164 visits per month funded by a combined grant award of $244,807.00. Of the active caseload served per month a combined average of 2 individuals per month received intensive visits (defined as greater than 6 visits per month).

The identified Desired Results for this pilot cycle focused on gathering baseline performance measures of selected health, social and economic indicators such as how many individuals served have a medical home; start prenatal care within first trimester and continue with ongoing regular visits throughout the pregnancy; are making positive gains in growth and development; have the basic supports they want and need to meet their basic needs. Annual measurement and analysis of these indicators ensure a positive difference in the health, social and economic well being of the recipients of these services.

Because it was no longer participating in the fee-for-service billing process which serves as the state's gateway to Medicaid data collection and distribution, the pilot lacked sophisticated data management, reporting, and analysis resources and capacity. In the spring of 2008, AHS directed that their four performance based grant pilots adopt a case rate billing structure going into their next grant cycles. Billing a case rate preserves flexibility and predictable budgets while restoring the important accountability connection to centralized Medicaid data collection and reporting.

A central hypothesis of the CIS Family Support pilots is that the shared aspect of family support services provides a controlled arena for learning about integrating the full complement of all three programs' services as CIS is envisioned, including effective funding and billing mechanisms. Much has been learned about CIS from the Family Support pilot about the One team composition and function, consent and communication issues, the need for common paperwork and interactive technology, the need for technical assistance supports, the need for AHS finance and data analyst resources. Integrating family support services across CIS makes practical sense. The systems issues involved in integrating family support are challenging and indicative of the challenges of implementing the full Children's Integrated Services Initiative.

NEXT STEPS AND PRIORITIES:

a. Continue CIS performance-based Family Support pilots through June 30, 2009

i. Evaluate a modified payment structure for Medicaid processing and reimbursement. Connect claims data to an integrated data management and accounting process to enable comprehensive data access, analysis, monitoring and reporting.
   a. Utilize a case rate billing structure with bundled services
   b. Capped maximum active monthly caseload
   c. Billing submitted monthly to EDS
   d. Monthly reporting back to OVHA, DCF, CDD and pilots
   e. Opportunity to earn enhanced rate for last 2 months if evidence that desired results are met

ii. Ensure delivery of Family Support services addresses Medicaid EPSDT Core Activities: outreach, informing, screening, assessment, and assistance to individuals in gaining access to needed medical, social, educational and other services. Utilize AAP Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, 3rd Edition as well as standard resources.

iii. Evaluate the group education component. Does it expand and support service delivery and allow for achievement of desired results?

iv. Evaluate the 6 month review process for individuals as defined in the TAG document

v. Implement common core documentation standards

vi. Implement and evaluate local collection of some data. Pilot sites will track desired results data for medical home, dental home, prenatal care received, and evidence of positive gains. This data will be documented in files by goal-centered progress notes and developmental screening and assessment results. Family surveys will be sent out by pilot sites and collected and tabulated by CDD.

b. Ensure State CIS Team continues to address pilot priorities as communicated through narrative reports, requests for technical assistance, and evaluation of files, parent surveys and claims data.

i. Update State CIS team work plan including identification of resources to support the work and a timeline for action.

ii. Continue to provide technical assistance for One Team
   a. Provide clarification for Family Support pilot roles in the context of CIS roles and services for all CIS teams statewide
   b. Provide clarification of one Team structure and levels of functioning
   c. Continue to forge partnerships at local and state level focused on building the multidisciplinary clinical consultation team for family support services

iii. Provide technical assistance for One Plan
   a. Provide clear and specific guidance about consent and confidentiality in addition to the guidance already produced
      i. AHS uniform consent promulgation process
      ii. Map types of consent needed from intake through discharge
   b. Provide consistent paperwork, forms, and documentation processes
      i. Avoid duplication of effort
      ii. Assist with buy-in efforts locally as needed
   c. Provide training and support for using One Plan in a way most conducive to regions and their direct service staff
      i. Develop instructional and supportive toolkit documents for One Plan
      ii. Consider regional trainings if possible

d. Continue to identify and address barriers to One Plan with pilot sites and other CIS partners
    i. Support pilot sites in providing specific feedback to state CIS team regarding One Plan and piloting the One Plan
    ii. Continue to work to ensure fidelity for billing, for adherence to standards and regulations, and for optimal service to families for all partners using the One Plan

iv. Create professional development opportunities and supports for the Family support worker with priority given to:

a. CIS Family Support Worker comprehensive orientation and ongoing training plan
b. Core documentation standards CIS and writing meaningful outcomes
c. Support teams to incorporate AAP Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, 3rd Edition as a resource for providing EPSDT services.

v. Monitor pilot goals and outcomes

a. Develop processes for evaluating pilot desired results and performance measures by February 2009
    i. Use to determine if pilot sites are eligible to bill for reimbursement at enhanced rates for last 2 months (May, June, 2009) of pilot period
b. Define and disseminate process for pilot site file reviews in March of 2009
c. Develop Family survey for mailing to families by May 15, 2009
d. Ensure dissemination of EDS claims data reports back to pilots, CDD, OVHA and DCF/AHS

vi. Continue to develop administrative infrastructure

a. Improve consistent communication from and with State CIS team
b. Evaluate new Case Rate Claims processing and reporting systems as a possible reimbursement structure for all of CIS
c. Continue to actively pursue implementation of a means for electronic sharing of client information, One Plan, and data collection and management
d. Collaboratively develop strategies for addressing increasing family support needs in Vermont communities